

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155524		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2014	
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT GLENBURN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 618 W GLENBURN ROAD LINTON, IN 47441			
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 18, 19, 20, 23, & 24, 2014</p> <p>Facility number: 000230 Provider number: 155524 AIM number: 100275000</p> <p>Survey Team: Melissa Gillis, RN-TC Cheryl Mabry, RN Diana McDonald, RN</p> <p>Census bed type: SNF/NF: 132 Total: 132</p> <p>Census payor type: Medicare: 16 Medicaid: 83 Other: 33 Total: 132</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 02, 2014; by Kimberly Perigo, RN.</p>		F000000	<p>July 14, 2014 Kim Rhoades, Director Long Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204-3003 RE: Glenburn Home Recertification and State Licensure Survey June 24, 2014 Dear Ms. Rhoades; The Indiana State Department of Health visited our facility on June 18, 19, 20, 23 and 24, 2014 for our Recertification and State Licensure Survey. By submitting the enclosed material we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. We respectfully request our plan of correction be considered our allegation of compliance effective July 24, 2014 and respectfully request a desk review. If you have any questions please feel free to contact me at the facility. Respectfully submitted, Le Ann Petit, HFA Administrator</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>A). Based on interview and record review, the facility failed to ensure each resident had the right to receive baths instead of showers and how many times a week to be bathed for 2 of 6 residents reviewed for individualized preferences and needs. (Resident #123, Resident #62)</p> <p>B). Based on interview and record review, the facility failed to accommodate a resident's shower preferences by not providing a shower bench in the shower room that the resident could use to maintain maximum independence of ADL's (Activities of Daily Living). (Resident #111)</p> <p>Findings include:</p> <p>A 1). On 6/20/14 at 9:59 a.m., Resident #123 indicated, when asked, Do you choose how many times a week you take</p>	F000246	<p>By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective July 24, 2014 to the state findings of the Recertification and State Licensure survey conducted on June 18, 19, 20, 23 and 24, 2014. F- 246 It is the intent of Glenburn Home to give each resident the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be dangered. A1) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident#</p>	07/24/2014			

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	<p>a bath or shower? "No." Do you choose whether you take a shower, tub, or bed bath? "No, prefer bath at times was taking daily bath at home."</p> <p>On 6/23/14 at 1:40 p.m., interview with Resident #123 indicated when asked if the shower team had ever asked her if she would like a tub bath. "No, no, they've never asked me that."</p> <p>The resident preference sheet dated 10/6/13, 9/4/12, and 1/15/14 indicated no bathing preferences for Resident #123.</p> <p>On 6/23/14 at 1:43 p.m., interview with the Activity Director/Social service for the special care unit indicated when asked how often is the resident preference sheet updated, "Once a year and we update it with the careplan and MDS (Minimum Data Set) assessment meetings every 3 months." Are these the current forms used for resident preferences? "Yes." Are the questions on the form how you determine the residents bathing preferences? "Yes." There were no questions on the form to address how often the residents would like to bathe. Who determines how often the residents are bathed? "The unit staff." Should the bathing preference be up to the staff? "No."</p>			<p>123 has completed a new revised resident preference form which asks what bathing preferences the resident has which includes bed bath, shower or tub bath along with the frequency of their bathing preference. The revised personal preference sheet will be completed by the Social Service Director and/ or their designee at least quarterly and with any significant change. Upon completion of the revised personal preference sheet this information will be forwarded to the Unit Manager who will be responsible for placing the information on an index card in the shower room for staff to review the information and also they will place the preference information on the CNA task list. The resident has been advised that at any time they would like to change any of their personal preferences they are to notify Social Services so that those changes can be accommodated.</p> <p>A2) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident # 62 has completed a new revised resident preference form which asks what bathing preferences the resident has which includes bed bath, shower or tub bath along with the frequency of their bathing preference. The revised personal preference sheet will be completed by the Social Service</p>			

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	<p>A 2). On 6/19/14 at 1:55 p.m., interview with Resident #62 indicated when asked, Do you choose whether you take a shower, tub, or bed bath? "No, they give us showers, but I would prefer a tub bath daily, because that is what I did at home."</p> <p>The resident preference sheet dated 9/25/13, indicated Resident #62 prefers to take a shower. There were no other preference sheets available for Resident #62.</p> <p>On 6/23/14 at 1:57 p.m., interview with the Activity Director for the west wing indicated, when asked how often are preference sheets updated, "Annually, or when there is a significant change. She [indicating Resident #62] is due in September of 2014." Can residents preferences change within a year. "Yes, I let them know this at the annual review and monthly council meeting. I let them know if there were any concerns it can be taken to their social service person or their nurse." Would the residents know that there are different options for bathing? "That is something we can probably add to the Quality Assurance meetings. I go around monthly and ask the residents if there is anything they need." So how is the preference sheet completed? "I rate each item on a scale of 1-5. If it's a 1 than that was important</p>				<p>Director and/ or their designee at least quarterly and with any significant change. Upon completion of the revised personal preference sheet this information will be forwarded to the Unit Manager who will be responsible for placing the information on an index card in the shower room for staff to review the information and also they will place the preference information on the CNA tasklist. The resident has been advised that at any time they would like to change any of their personal preferences they are to notify Social Services so that those changes can be accommodated. B1) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident#111 has been provided a new shower bench in the shower room to accommodate her personal preference in bathing to provide her as much independence with bathing as possible. The resident has also completed a new revised resident preference form which asks what bathing preferences the resident has which includes bedbath, shower or tub bath along with the frequency of their bathing preference. The revised personal preference sheet will be completed by the Social Service Director and/ or their designee at least quarterly and with any significant change. Upon</p>		

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	<p>to the residents. This is something the Quality team can check into."</p> <p>On 6/23/14 at 9:18 a.m., interview with the DON indicated, when asked if residents have options on whether they take a tub bath or shower, "Yes, they do." When asked is there a tub in the facility, the DON indicated, " Yes, we have a tub." When asked is there a preference sheet indicating resident's bathing preferences? "Yes, Activities does preference sheets on each person and the shower team ask the resident's before they implement the shower if they want a shower or bath."</p> <p>B). Resident #111's clinical record was reviewed on 6/20/14 at 2:00 p.m.. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, congestive heart failure, hypertension, anemia, and hypothyroidism.</p> <p>BIMS (Brief Interview for Mental Status) score was a 15 on 3/19/14. A score of 13-15 indicates the resident is cognitively intact.</p> <p>MDS (Minimum Data Set) dated 3/19/14, Functional Status - Activities of Daily Living (ADL) Assistance, personal</p>		<p>completion of the revised personal preference sheet this information will be forwarded to the Unit Manager who will be responsible for placing the information on an index card in the showerroom for staff to review the information and also they will place the preference information on the CNA task list. The resident has been advised that at any time they would like to change any of their personal preferences they are to notify Social Services so that those changes can be accommodated. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide review of each resident's personal preferences has been completed. Social services and/or designee have completed the revised personal preference form on each resident. The information has been documented on the index cards filed in the shower rooms and the CNA task lists have been up-dated with the resident's information. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has revised their protocol as it relates to the frequency of gathering personal preference information. The personal preference tool has been revised and the frequency in</i></p>				

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	<p>hygiene section, indicated Resident #111 "was a limited assistance, resident highly involved in activity, staff provide guided maneuvering of limbs or other non-weight-bearing assistance." Resident #111 "is a one person physical assist."</p> <p>Interview on 6/20/14 at 11:05 a.m., with Resident #111 indicated she would like to do her own personal private area care, but could not longer do so, because the bench she used had been removed from service.</p> <p>Interview on 6/24/14 at 11:46 a.m., with Shower Aide #1, indicated there is a plastic bench in the shower room that is not weight bearing and was removed from service for safety reasons and now used for clothes and briefs. There are 2 small benches in the shower room for residents to sit on who want to do there own shower, including personal care. The Shower Aide #1 indicated one shower bench was being used as a desk chair in an unused shower room. The Shower Aide #1 indicated the shower aide's would bathe resident completely or assist a resident to clean themselves during a bath.</p> <p>Observation 6/24/14 at 12:06 p.m., entered shower room and Shower Aid #1 indicated the white plastic bench, which</p>		<p>which the tool has been changed as well. The facility practice now is that the personal preference tool will be completed within 72hours of admission, then quarterly and with any significant change of condition. The resident has been advised that at any time they would like to change any of their personal preferences they are to notify Social Services so that those changes can be accommodated. The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor compliance with residents' personal preferences. This tool includes the resident's choice of bathing (tub bath, bed bath, shower) and any personal preferences as it relates to adaptive bathing equipment. The tool will also monitor the resident's choice in frequency of bathing. The tool will be completed by the Director of Nursing and/or her designee weekly for four weeks, then monthly for two months and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.</p>				

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F000256 SS=D	<p>had two open packages of incontinence briefs on top of the seat. There was one shower bench, which was being used as a desk chair. The other shower bench was in rehabilitation shower room.</p> <p>3.1-3(v)(1)</p> <p>483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. Based on observation and interview, the facility failed to ensure comfortable environment for residents who prefer more lighting in their room for 2 of 2 residents observed in a sample of 2 for a comfortable environment. (Resident #62, Resident #123)</p> <p>Findings include:</p> <p>1). Resident #62's clinical record was reviewed on 6/20/14 at 9:30 a.m. Diagnoses included, but were not limited to: hypertension, diabetes and hyperlipidemia.</p> <p>The current MDS (Minimum Data Set) assessment dated 4/16/14, indicated a BIMS (Brief Interview Mental Status) score of 15, which indicated resident was</p>		F000256	<p>It is the intention of Glenburn Home to provide adequate and comfortable lighting levels in all areas. <i>The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #62 has had a new light put up in her room above the area in which the resident wanted to put on her makeup. A new mirror was also put in the area. In addition a new ceiling light has been installed. The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #123 has had a new light installed in their room. The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit of all residents'</i></p>		07/24/2014	

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	<p>cognitively intact.</p> <p>On 6/19/14 at 1:57 p.m., interview with Resident #62 indicated, when asked if there were problems with the lighting in the building? " It is awfully dark in the rooms. I can't see to put on make up. I've complained to maintenance a lot." Did maintenance say they would fix the problem? "No, they don't say anything nor do anything."</p> <p>On 6/19/14 at 1:57 p.m. observation of Resident #62's room indicated dimmed overhead lights and the area is dimmed where Resident #62 would prefer to put her makeup on.</p> <p>2). On 6/20/14 at 10:02 a.m., interview with Resident #123 indicated when asked if she had problems with the lighting in the building? "Yes, too dim in my room."</p> <p>3.1-19(dd)</p>			<p>rooms was conducted to ensure adequate lighting was being provided. Additional lighting has been added to all rooms of residents which during the completion of the audit requested additional lighting. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that the facility has added to the maintenance department's weekly responsibilities the task of checking each room for replacement of any burnt out bulbs. In addition the staff has been directed that upon identifying any burnt out light bulbs to complete a maintenance slip so that the bulb can be replaced timely. In addition Social Services and/or designee is interviewing residents within 72hours of admission, quarterly and with any significant change related to their personal preference on room lighting. Upon identifying any additional lighting needs during the interview, Social Services will complete a maintenance request slip to address this concern. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to ensure adequate lighting is provided in accordance with each resident's personal preference. This tool will be completed by</i></p>			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident's call light was within reach for a resident capable of notifying the facility staff of need for assistance for 1 randomly observed resident. (Resident #16)</p> <p>Findings include:</p> <p>Resident #16's clinical record was reviewed on 6/18/14 at 3:00 p.m. Diagnoses included, but were not limited to: hypertension, diabetes, hyperlipidemia, and heart failure.</p> <p>The current MDS (Minimum Data Set) assessment dated 4/30/14, indicated a BIMS (Brief Interview Mental Status)</p>		F000323	<p>Director of Maintenance and/or his designee weekly for four weeks, then monthly for two months and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.</p> <p>It is the intention of Glenburn Home to ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accident. The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #16 now has his call light placed where it is accessible to the resident at all times while he is in the room. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a housewide audit has been completed. All residents were found to have their call lights within reach. The measures or systematic changes that have</i></p>		07/24/2014	

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	<p>score of 9, which indicated resident was cognitively intact. The MDS indicated Resident #16 needed extensive assist of one staff member for walking in the room, toileting, balancing during transition and not steady, only able to stabilize with human assistance. Resident #16 uses a wheelchair for mobility service.</p> <p>On 6/18/14 at 2:00 p.m., observation of Resident #16 in his room in a wheelchair indicated, Resident #16's call light to be hanging over a glove box on the wall behind the bed. When asked if he knew how to use the call light, Resident #16 indicated, "Yes." When asked to demonstrate, Resident #16 was observed to wheel himself over to the bed, reach 3 times for the call light and not able to grab. Resident #16 was observed to get out of the wheelchair by himself with the wheelchair alarm sounding, and grabbed the call light. When asked if he should be getting out of the wheelchair by himself indicated, "Well I had no choice." Resident #16 was observed to sit down the in wheelchair. Scheduler #1 was observed to enter the room to assist Resident #16. When asked if Resident #16 suppose to get out of his wheelchair on his own, indicated "No." When asked if Resident #16 could reach the call light from his wheelchair if it was hanging on</p>		<p>been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been provided for all staff members on the facility policy regarding call light placement. A copy of this policy was given to all employees. The Call Light Policy has also been added to the new hire packet which will also be a part of their orientation to the facility. Annual in-servicing will be provided to all employees on the placement of call lights and the facility policy. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor call light placement. This tool will be completed by the Unit Managers and/or designee. The tool will be completed every shift for seven days, then once a week for three weeks, then monthly for two months and then quarterly for three quarters. The completed tools will be reviewed by the Director of Nursing to determine if any additional action is warranted. The Director of Nursing or her designee will report to the Quality Assurance committee the outcome of these audits.</i></p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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F000329	<p>the wall, The scheduler #1 indicated, "No." When asked if Resident #16 was a fall risk, Scheduler #1 indicated, "Yes." Observed the Scheduler to remove the call light off the box of gloves and place on Resident #16's bed.</p> <p>On 6/19/14 at 2:30 p.m., requested a copy of the facilities policy and procedure for call lights. The policy and procedure dated 5/28/14, provided by the Administrator on 6/23/14 at 10:20 a.m., and indicated as current. Review of the policy indicated, "A fall prevention program will be implemented and maintained to assure the safety of all residents admitted to the facility. The program will be inclusive of measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate staff interventions to assure adequate supervision is provided and assistive devices are utilized when necessary...."</p> <p>3.1-45(a)(2)</p>						

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SS=E	<p>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents' drug regimen was free from unnecessary medications in that antipsychotic, antidepressants and antianxiety medications were given without adequate monitoring of side effects as indicated by facility policy for 3 of 5 residents reviewed for unnecessary medication use. (Resident #25, Resident #99, Resident #95)</p> <p>Findings include:</p>		F000329	<p>It is the intention of Glenburn Home to ensure residents drug regimen are free from unnecessary medications in that antipsychotic, antidepressants and antianxiety medications are given with adequate monitoring of side effects. 1) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #25 is now being monitored for side effects everyshift. The facility has implemented the use of a spreadsheet to monitor for possible side effects. This form</p>		07/24/2014	

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	<p>1). Resident #25's clinical record was reviewed on 06/18/2014 at 1:43 p.m. Diagnoses included, but were not limited to anxiety, depression, hypertension, dementia, delusional disorder and GI (gastro intestinal) bleed.</p> <p>Resident #25 received the following medications:</p> <p>Seroquel (antipsychotic) 50mg daily since November 2012 Xanax (antianxiety) 2mg tid (three times a day) since November 2009 Celexa (antidepressant) 40mg daily since September 2010</p> <p>On 6/23/14 at 11:07 a.m., interview with Unit 6's Manager indicated, when asked how do you monitor for side effects for residents who receive psychotropic medications, "We watch their behavior." Is there a sheet or form you use to monitor medication side effects? "No, we look them up in the drug book." Is there a sheet or form used by the nurses to document and monitor side effects. "No, we would document if there was something abnormal."</p> <p>Careplan dated 3/31/14 indicated, "...psychotropic medication: Celexa, DX [diagnosis] Depression; ... [Name of</p>			<p>has been placed in the resident's MARs and is completed by the nurse each shift. 2) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #99 is now being monitored for side effects every shift. The facility has implemented the use of a spreadsheet to monitor for possible side effects. This form has been placed in the resident's MARs and is completed by the nurse each shift. 3) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #95 is now being monitored for side effects every shift. The facility has implemented the use of a spreadsheet to monitor for possible side effects. This form has been placed in the resident's MARs and is completed by the nurse each shift. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit was conducted on all residents receiving psychotropic medications. The facility has implemented the use of a spreadsheet to monitor for possible side effects. Each resident on any psychotropic medication is now being monitored each shift for possible side effects. The measures or systematic changes that have</i></p>			

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	<p>resident #25] will be free from adverse reactions and side effects of medication through the next review period, ...</p> <p>6/10/14 Anti-Depressant: Medication Celexa Observe the patient closely for significant side effects and report to the physician. SIDE EFFECTS: Common-sedation, Drowsiness, Dry Mouth, Blurred Vision, "Urinary Retention, Tachycardia, Muscle Tremor, Agitation, Headache, Skin Rash, Photosensitivity [skin], Excess Weight Gain., special attention for: Heart Disease, Glaucoma, Chronic Constipation, Seizure Disorder, Edema."</p> <p>Careplan dated 6/10/14 "...Seroquel, ... Monitor Dry Mouth, Constipation, Blurred Vision, EXTRA PYRAMIDAL REACTION, Weight Gain, ... Loss of Appetite, ... NURSING ALERT: Tardive Dyskinesia, Seizure Disorder, ... Jaundice. Monitor behavior on medication sheet."</p> <p>Careplan dated 6/10/14 "Anti Anxiety ...Xanax Observe the patient closely for significant side effects and report to the physician. SIDE EFFECTS: Sedation, Drowsiness, Ataxia [drunk walk], ... NURSING ALERT: If given with other sedatives or hypnotics, and alcohol. Monitor behavior on medication sheet."</p>		<p>been put into place to ensure that the deficient practice does not recur is that the facility has revised their policy and procedure on Psychotropic Drug Use, Monitoring and Reduction to include the use of a spreadsheet for psychotropic drug monitoring of side effects. The facility has conducted a mandatory in-service on the revised policy and the implementation of the psychotropic drug side effects monitoring. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to ensure the residents on psychotropic medications are being monitored for side effects. This tool will be completed by the Director of Nursing and/or her designee. The tool will be completed weekly for four weeks, then monthly for two months and then quarterly for three quarters. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.</i></p>				

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	<p>There was no documentation provided for monitoring side effects for Resident #25's Xanax (for treating anxiety), Seroquel (for treatment of major depressive disorder), or Celexa (treatment for depression).</p> <p>2). Resident #99's clinical record was reviewed on 6/20/14 at 2:00 p.m. Diagnoses included, but were not limited to: small bowel observation, hyperlipidemia, osteoporosis, psychosis, and anxiety.</p> <p>Medications included, but were not limited to: quetiapine fumarate (Seroquel), 50 mg daily, alprazolam (Xanax) 0.5 mg bid (two times a day), this medication treats anxiety, and Remeron 15 mg daily for appetite stimulant. Remeron is an antidepressant.</p> <p>Resident #99 has been on Seroquel and Xanax since April, 2014 and Remeron since June, 2014.</p> <p>Care plans included: "Interdisciplinary Care Plan: Antidepressant/Antipsychotic/Anxiolytic/Hypnotic Medications, dated 3/29/14 and updated on 4/2/14, 4/11/14 and 6/16/14: Goal:...Resident will be free from</p>						

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	<p>adverse reactions and side effects of medication...2. Be aware of and observe for side effects of medication 3. Notify physician of any changes or complications 4. Observe for any mood or behavior changes...Xanax: Observe the patient closely for significant side effects and report to the physician. Side effects: Sedation, drowsiness, ataxia (drunk walk)...Seroquel...observe the patient closely for significant side effects...Tardive Dyskinesia, seizure disorder...Remeron...Observe the patient closely for significant side effects...heart disease, glaucoma, chronic constipation, seizure disorder..."</p> <p>There was no documentation provided for the monitoring of side effects for Resident #99's medications.</p> <p>3). Resident #95's clinical record was reviewed on 6/23/14 at 9:30 a.m. Diagnosis included, but were not limited to: personality disorder, atrial fibrillation, cerebrovascular accident, and Alzheimer's dementia with behaviors.</p> <p>Medications included, but were not limited to: venlafazine HCL</p>						

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	<p>(hydrochloride) ER (Extended Release) 75 milligrams (mg) daily for mood. Venlafazine is an antidepressant. Quetiapine fumarate (an antipsychotic) 50 mg bid (two times a day) for agitation, and Depakote 250 mg (an anticonvulsant) bid for behavior.</p> <p>Resident #95 has been on these medications since April, 2014.</p> <p>Care plans included: "Interdisciplinary Care Plan, dated 5/1/14: "Depakote...1. Administer medication as ordered. 2. Be aware of and observe for side effects of medication. 3. Notify physician of any changes or complications. 4. Observe for any mood or behavior changes...Depakote...side effects: Diarrhea, dizziness, drowsiness, hair loss, blurred/double vision...ringing in ears, shakiness (tremor), unsteadiness..."</p> <p>"Psychotropic Medication, dated 5/1/14: "Psychotropic Medication...Goal...[Resident's name] will be free from adverse reactions and side effects of medication through the next review period...2. Be aware of and observe for side effects of medication. 3. Notify physician of any changes or</p>						

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	<p>complications. 4. Observe for any mood or behavior changes...Observe the patient closely for significant side effects and report...Seroquel(quetiapine fumarate)...Side effects...drowsiness, dry mouth, blurred vision...nursing alert: Tardive Dyskinesia, seizure disorder, chronic constipation..."</p> <p>"Psychotropic Medication, dated 5/1/14: [Resident's name] takes the psychotropic medication Effexor (venlafazine HCL) for Mood...Goal...will be free from adverse reactions and side effects...2. Be aware of and observe for side effects of medication. 3. Notify physician of any changes...4. Observe for any mood or behavior changes...Effexor...side effects...agitation, headache, skin rash...heart disease, glaucoma, seizure disorder..."</p> <p>"Attention Seeking Behavior, dated 2/18/14:...3. Administer and monitor the effectiveness and side effects of medication as ordered..."</p> <p>There was no documentation provided for monitoring of side effects or any place to monitor for side effects for Resident #95's medications.</p>						

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	<p>Interview on 6/23/14 at 11:00 a.m., with the Director of Nursing (DON), indicated when asked if there was anything to show where there was documentation which staff monitored for any side effects, "No, there isn't anything. I guess we need to start doing that."</p> <p>On 6/24/14 at 9:23 a.m., the Administrator provided the "Psychotropic Drug Use, Monitoring and Reduction", dated 6/23/14, and indicated the policy was the one currently used by the facility. The policy indicated, "Psychotropic medications, when used inappropriately can lead to adverse reactions and negative outcomes in resident health and quality of life...Monitoring will determine the resident's continued need of the medication at the current dosage, and whether the anticipated outcomes are being met. Ongoing monitoring helps to identify when optimal benefit has been achieved, if the drug needs to be discontinued or replaced with a less potent medication. Procedure:...6. A Psychotropic Drug Monitoring Sheet will be included in the MARS (Medication Administration Records) for documentation of any side effects</p>						

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F000371 SS=F	<p>of the medication. Staff will document any side effects on this form and report to the unit manager for review."</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure staff used proper handwashing technique in the kitchen and while passing drinks, failed to ensure food had been discarded from 1 out of 1 dry storage room and 1 of 1 walk in refrigerator, when the</p>		F000371	<p>It is the intention of Glenburn Home to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store prepare,distribute and serve food under sanitary conditions. As discussed with Kim Perigo by</p>		07/24/2014	

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	<p>expiration date had passed as indicated by the facility policy and 410 IAC Retail Food Establishment Sanitation Requirements Manual were not followed property. This deficient practice had the potential to affect 127 out of 127 residents who are served from the kitchen.</p> <p>Findings include:</p> <p>1). On 6/18/14 at 10:30 a.m., the following was observed in the dry storage room:</p> <p>2 cartons of cranberry base with a received date of 2/11/2014 no expiration date, 8 boxes of traditional Rice Pilaf no receive date or expiration date, 6 bags Jello cheese cake mix with no receive date nor expiration date. The DM indicated " We keep everything for 6 months. I'll have to check when I ordered it."</p> <p>The DM was observed to remove the bags of cheese cake mix and throw in the trash.</p> <p>2). On 6/18/14 at 10:13 a.m., the following were observed in the walk in refrigerator:</p>			<p>phone on 07-10-2014, an expiration date is not required on food. 1) The corrective action taken for those residents found to be affected by the deficient practice is that no specific residents were identified in the survey however all residents have the potential to be affected by this practice. The corrective action taken was that all of the items identified during survey with no received date were immediately discarded. 2) The corrective action taken for those residents found to be affected by the deficient practice is that no specific residents were identified in the survey however all residents have the potential to be affected by this practice. The corrective action taken was that the box of mushy oranges was immediately discarded. 3) The corrective action taken for those residents found to be affected by the deficient practice is that that no specific residents were identified in the survey however all residents have the potential to be affected by this practice. The corrective action taken is that the facility has placed a clock with a secondhand at the side of the hand washing in the kitchen. The staff members identified as the Dietary Manager, Cook #1 and DA #1 has received re-in-servicing on the facility hand washing policy and procedure. 4) The corrective action taken for those residents found to be</p>			

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	<p>A box of mushy oranges with a received date of May 2014. The DM indicated "I'll just throw that box away."</p> <p>3). On 6/19/14 at 10:10 a.m., observed the following kitchen staff to handwash for less than 20 seconds:</p> <p>The Dietary Manager entered the kitchen for observation and was observed to handwashed for 18 seconds. Cook #1 was preparing lunch for residents and handwashed for 10 second,13 seconds and 15 seconds. DA #1 was observed during dietary preparation to handwashed for 12 seconds.</p> <p>4). At 10:15 a.m. on 6/19/14, Cook #1 was observed on her knee trying to place a pan in the oven, stood up, pulled down her scrub top, walked over to the convection oven and placed the pan in the oven. No handwashing was observed. Cook #1 was observed to retrieve a cleaning cloth from a bucket of water, clean the puree machine, walk to the sink and handwash for 13 seconds. She then walked over to the convection oven to get the chicken tray.</p> <p>5). At 10:18 a.m. on 6/19/14, DA #1 was observed to exit the kitchen several times to enter the walk in refrigerator and return to the prep table and poured fluids</p>				<p>affected by the deficient practice is that that no specific residents were identified in the survey however all residents have the potential to be affected by this practice. The corrective action taken is that the staff member identified as Cook #1 has been re-in serviced on proper infection control practices as it relates to hand washing in the storage, preparation, distribution and serving of food. 5) The corrective action taken for those residents found to be affected by the deficient practice is that that no specific residents were identified in the survey however all residents have the potential to be affected by this practice. The corrective action taken is that the staff member identified as DA #1 has been re-in serviced on proper infection control practices as it relates to hand washing in the storage, preparation,distribution and serving of food. The staff member has also been in-serviced on the proper us of gloves in food preparation to include hand washing prior to the placement of gloves. 6) The corrective action taken for those residents found to be affected by the deficient practice is that that no specific residents were identified in the survey however all residents have the potential to be affected by this practice. The corrective action taken is that the staff member identified as Cook #1 has been re-in serviced on</p>		

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	<p>for lunch trays. No handwashing was observed. DA #1 was observed to put on gloves and make a sandwich for a resident. No handwashing was observed before making the sandwich. She removed the gloves, threw them in the trash can, handwashed for 15 seconds, walked back to the prep table, repositioned her name tag, and continued to prepare thicken liquids. No handwashing was observed after adjusting her badge.</p> <p>6). At 10:25 a.m. on 6/19/14 Cook #1 was observed to walk in the dirty dish area to take a pot, walk out of dirty dish area, walked over to the prep area, retrieve aluminum foil, cover the mechanical soft chicken, and place it in the convection oven. No handwashing was observed.</p> <p>7). On 6/19/14 at 10:45 a.m., observed Cook #1 to rub the back of her scrub top, get aluminum foil and cover puree chicken. No handwashing was observed. When asked when should she handwash, Cook #1 indicated, " Every time you change task, before gloving, when touch the trash, picking up any trash, or paper, when you handle different forms of food, touch any contaminate." Did you do that? " I hope I did." When asked how long should she handwash, Cook #1</p>		<p>proper infection control practices as it relates to hand washing in the storage, preparation,distribution and serving of food. 7) The corrective action taken for those residents found to be affected by the deficient practice is that that no specific residents were identified in the survey however all residents have the potential to be affected by this practice. The corrective action taken is that the staff member identified as Cook #1 has been re-in serviced on proper infection control practices as it relates to hand washing in the storage, preparation,distribution and serving of food. 8) The corrective action taken for those residents found to be affected by the deficient practice is that the staff member identified as QMA # 1 has received one on one education on the proper handling,transporting and serving of beverages. In addition upon observation/assessment of the resident identified as resident #54 they have not had any adverse response to receiving the uncovered beverage. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents have the potential to be affected by this practice however no residents have displayed any signs or symptoms related to this deficient practice. The</i></p>				

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	<p>indicated, "20 seconds." When asked how do you know that you handwashed for 20 seconds? Cook #1 indicated, "I count to 20." The DM indicated, when asked how can assure that everyone is handwashing for 20 seconds, "I guess we need to get a second hand clock."</p> <p>On 6/19/14 at 10:55 a.m., DA #1 indicated when asked when should she handwash, "Every time you come back in the kitchen, touch something, leave kitchen, before gloving." When asked if she had done that, DA #1 indicated, "No."</p> <p>8). On 6/19/14 at 2:20 p.m., observed QMA (Qualified Medical Assistant) #1 to enter Room #3 with an uncovered glass of fluid. The resident refused the drink. QMA #1 was observed to exit the room, walked down the hall with the drink in her hand, enter into Room #2 and give the drink to Resident #54.</p> <p>QMA #1 indicated, When asked if she should take an uncovered drink from one resident's room to another? "I don't know." QMA #1 went to ask the Unit 6's Manager. QMA #1 returned and indicated, "No, I should have discarded it (indicating the drink)."</p> <p>On 6/19/14 at 3:38 p.m., the</p>		<p>measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service for all staff has been provided on the facility handwashing policy and procedure. The staff was also instructed on the proper serving of beverage to the residents' rooms including the discarding of refused beverages. In addition a mandatory in-service has been provided for all the dietary staff on the proper storage, preparation, distribution and serving of food under sanitary conditions. The staff was directed on the proper processing of dating food items upon receipt prior to storage. This in-service also included proper hand washing in conjunction with glove application and removal</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that a Quality Assurance tool has been developed and implemented to monitor for compliance in the proper storage, preparation, distribution and serving of food under sanitary conditions. This tool will be completed by the Dietary Manager and/or her designee. This tool will be completed weekly for four weeks, then monthly for two months and then quarterly for three quarters. The outcome will be review at the Quality Assurance meeting to determine if any additional action</i></p>				

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	<p>Administrator provided "Food Safety Receiving and Shelf life" dated 6/19/2014, and indicated that was the policy currently used by the facility. The policy indicated, "Although most items exceed a 6 month shelf life Glenburn Home's policy is to discard any food items that exceed 6 months of storage. ...2. The approved food supplier provides pre-determined shelf life based on the day of purchase. 3. Food item shelf life is found on the approved food supplier's website. 4. Dates are monitored during receiving and storage."</p> <p>Review on 6/25/14 at 3:00 p.m., of the "RETAIL FOOD ESTABLISHMENT SANITATION REQUIREMENT Manual 410 IAC 7-24" dated November 13, 2004, indicated ..."Hand cleaning and drying procedure ... (a) Food employees shall, except as specified in section 343 (c) of this rule, clean their hands and exposed portions of their arms with a cleaning compound at a hand washing sink that is equipped as specified by vigorously rubbing together the surfaces of their lathered hands and arms for at least twenty (20) seconds in water ... When to wash hands (a) Food employees shall clean their hands and exposed portions of their arms as specified ... immediately before engaging in food preparation. ... and the following... (6)</p>		<p>is warranted. In addition another Quality Assurance tool has been developed and implemented to monitor the proper serving of meals/snacks/beverages to residents in accordance with acceptable standards of infection control practices. This tool will be completed by the Director of Nursing and/or her designee. The tool will be completed daily each meal for one week then weekly for four weeks, then monthly for two months and then quarterly for three quarters. The outcome will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted. It is an ongoing responsibility of the Food Service Manager to monitor the storage, preparation, distribution and serving of food under sanitary conditions</p>				

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F000431 SS=B	<p>After handling soiled surfaces, equipment, or utensils ... after engaging in other activities that contaminate the hands."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for</p>						

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	<p>storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident's out of date insulin medication had been discarded from the medication storage refrigerator (1 of 1) in the medication room located on the 500 hall.</p> <p>Findings Include:</p> <p>Observation on 6/24/14 at 11:15 a.m., LPN #2 unlocked the storage refrigerator locate in the 500 hall medication room. Resident #141 had an opened Humalog insulin vial with the open date on the bottle of 5/22/14.</p> <p>Interview on 6/24/14 at 11:20 a.m., with LPN #2 indicated the medication belonged to a resident on the 400 hall and the Humalog was more then 30 days old.</p> <p>Record review on 6/24/14 at 4:45 p.m., the DON provided "Pharmaceuticals Storage" policy, dated 6/24/14, and indicated the policy was the one currently used by facility. The policy indicated, "...</p>		F000431	<p>It is the intention of the Glenburn Home for Drugs and biologicals used in the facility to be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The corrective action taken for those residents found to be affected by the deficient practice is that the undated insulin of the resident identified as resident #141 was immediately discarded and a new bottle of Humalog was obtained for resident use. <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that a house wide audit of all residents receiving insulin was conducted. No other undated/outdated insulin was found. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all licensed nurses on the proper storage and disposal of medications. The corrective action taken to monitor</i></p>		07/24/2014	

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F000441 SS=D	<p>After opening insulin vials and insulin pens will be storage in the locked medication cart and dated upon opening. Vials and pens will be discarded after thirty days of the open date. ..."</p> <p>3.1-25(o)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to</p>			<p><i>to assure performance to assure compliance through quality assurance is a Quality Assurance tool has been developed and implemented to monitor the proper disposal of outdated insulin vials. This tool will be completed by the Director of Nursing and/or her designee. The tool will be completed weekly for four weeks, then monthly for two months and then quarterly for three quarters. The outcome will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.</i></p>			

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	<p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A). Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed according to facility policy in that a facility staff failed to hand wash during a dressing change for a randomly observed resident. (Resident #25)</p> <p>B). Based on observation and record review, the facility failed to ensure infection control practices were followed related to taking uncovered drinks from one residents room to another residents room for 1 of 2 randomly residents served a drink on the 600 unit. (Resident #54) (QMA #1)</p> <p>Findings include:</p> <p>A). Observation on 6/23/14 at 9:45</p>	F000441	<p>It is the intention of the Glenburn Home to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. A) The corrective action taken for those residents found to be affected by the deficient practice is that the resident identified as resident #25 is now receiving dressing changes in accordance with acceptable standards of infection control practice. The staff member identified as LPN #3 has received one on one education on the acceptable standard of infection control practices as it related to glove usage, handwashing, and dressing changes. B) The corrective action taken for those residents found to be affected by the</p>	07/24/2014			

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	<p>a.m., indicated LPN #3 was changing wound dressings for Resident #25. LPN #3 washed her hands before the dressing change and applied gloves. LPN #3 then put Resident #25 on her right side and took off the old dressings to Resident #25's hip and buttock. LPN #3 then took off her gloves and applied new ones. She cleaned the wound and put on the dressings for the wound. LPN #3 then put the resident on her left side. LPN #3 took off the old dressings from Resident #25's wound on resident's left hip and buttock. LPN #3 then took off her gloves and applied new gloves. LPN #3 cleaned the wounds and applied the dressings for the wounds. After LPN #3 was done with the care, she put Resident #25 on her back and fixed the covers back over her. LPN #3 did not remove her gloves after the completion of wound care or hand wash in between wounds.</p> <p>At that time an interview with LPN #3 indicated when asked what was the policy on handwashing, "Oh, I should've washed my hands between dressing changes." When indicated she used the same gloves to fix Resident #25's covers, "I will get them changed."</p>			<p>deficient practice is that the staff member identified as QMA # 1 has received one on one education on the proper handling, transporting and serving of beverages. In addition upon observation/assessment of the resident identified as resident #54 they have not had any adverse response to receiving the uncovered beverage. A) <i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that any resident with a wound has the potential to be affected by this deficient practice however no residents with wounds have demonstrated any signs or symptoms related to this deficient practice. B) The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that all residents who receive beverages have the potential to be affected by this practice however no residents have displayed any signs or symptoms related to this deficient practice. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that a mandatory in-service has been conducted for all staff on the acceptable standards of infection control practices. The staff was instructed that beverages served from the juice dispenser in the</i></p>			

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	<p>On 6/23/14 at 10:45 a request for policy on wound care was made, but no policy was given.</p> <p>On 6/23/14 at 10:20 a.m., the Administrator provided the "Hand Washing", dated 5/28/14 and the "Infection Control" policy, dated 6/23/14, and indicated the policies were the ones currently used by the facility. The policy "Hand Washing" indicated, "Policy: The single most important barrier to the spread of infections or the prevention of self-infection for all employees working in a healthcare environment is Hand Washing...It is essential that all employees follow good hand washing techniques...Procedure: 1. Every employee will cleanse their hands before and after every resident care encounter. 2. If protective gloves are worn with the care encounter, hand cleansing will occur after removal of gloves..." The "Infection Control" policy indicated, "...14. All facility personnel are required to routinely wash hands and use appropriate barrier precautions to prevent transmission of infections..."</p> <p>B). On 6/19/14 at 2:20 p.m., observed QMA (Qualified Medical Assistant) #1 to enter Room #3 with an uncovered glass of fluid. The resident refused the drink. QMA #1 was observed to exit the room</p>				<p>dining area required to be covered before transport. The staff was also instructed on discarding beverages/snacks that are refused by a resident. In addition the nurses were instructed on the acceptable standards of infection practices as it relates to proper handwashing, glove usage during wound care. <i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is Quality Assurance tools have been developed and implemented to monitor infection control practices as it relates to handwashing, glove usage, dressing changes and the transporting of beverages/snacks to resident rooms. This tool will be completed by the Director of Nursing and/or her designee. The tool related handwashing/infectioncontrol will be weekly for four weeks, then monthly for two months and the quarterly for three quarters. The tool on resident snack/beverage distribution will be completed daily for seven days, then weekly for three weeks, then monthly for two months and then quarterly for three quarters. The outcomes of both tools will be reviewed at the Quality Assurance meeting to determine if additional action is warranted.</i></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

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	<p>and walked down the hall with the drink in her hand. QMA #1 entered Room #2 and gave the drink to the Resident #54.</p> <p>QMA #1 indicated, when asked if she should take an uncovered drink from one resident's room to another? "I don't know." QMA #1 then went to ask the Unit 6's Manager. QMA #1 returned and indicated, " No, I should have discarded it. (indicating the drink)."</p> <p>3.1-18(I)</p>						